

4 Plan Options at a Glance



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Plan Options and Benefits Highlights ■ Effective September 1, 2010

	PPO Plans			
	ActiveCare 1-HD (Network)	ActiveCare 1 (Network)	ActiveCare 2 (Network)	ActiveCare 3 (Network)
Service Area	Statewide			
Primary Care Physician (PCP) required to direct care and for benefits to be paid?	No	No	No	No
Deductible <i>(per plan year; individual/family)</i>	\$2,400/\$2,400	\$1,200/\$3,000	\$500/\$1,500	None
Meets IRS definition of high deductible health plan?	Yes	Yes, for individual coverage only, not family	No	No
Out-of-Pocket Maximum <i>(per plan year; individual/family)</i>	\$3,000/\$5,000 <i>(does not include deductible or copays)</i>	\$2,000/\$6,000 <i>(does not include deductible or copays)</i>	\$2,000/\$6,000 <i>(does not include deductible or copays)</i>	\$1,000 per individual <i>(does not include deductible or copays)</i>
Office Visit Copay	20% after deductible	20% after deductible	\$30 for primary; \$50 for specialist	\$20 for primary; \$30 for specialist
Preventive Care Copay	First \$500, plan pays 100%	First \$500, plan pays 100%	\$30 for primary; \$50 for specialist	\$20 for primary; \$30 for specialist
Inpatient Hospital	20% after deductible	20% after deductible	\$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year), plus 20% after deductible	\$100 copay per day (\$500 maximum copay per admission; \$1,500 maximum copay per plan year), plus 20%
Emergency Room	20% after deductible	20% after deductible	\$100 copay plus 20% after deductible <i>(copay waived if admitted)</i>	\$100 copay plus 20% <i>(copay waived if admitted)</i>
Maximum Lifetime Benefits	Unlimited	Unlimited	Unlimited	Unlimited
Prescription Drug				
Drug Deductible <i>(per person, per plan year)</i>	Subject to plan year deductible	Subject to plan year deductible	\$50	\$50
Retail Short Term <i>(generic/preferred/non-preferred)</i>	20% after deductible	20% after deductible	\$10/\$25/\$45	\$10/\$25/\$40
Retail Maintenance <i>(generic/preferred/non-preferred)</i>	20% after deductible	20% after deductible	\$15/\$35/\$60 <i>(after second fill)</i>	\$15/\$35/\$55 <i>(after second fill)</i>
Mail Order <i>(generic/preferred/non-preferred)</i>	20% after deductible	20% after deductible	\$20/\$62.50/\$112.50	\$20/\$62.50/\$100
Maximum Plan Year Prescription Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Cost of Coverage (per Month)				
Employee Only	\$262.00	\$297.00	\$396.00	\$533.00
Employee and Spouse	\$642.00	\$677.00	\$901.00	\$1,213.00
Employee and Child(ren)	\$409.00	\$474.00	\$630.00	\$850.00
Employee and Family	\$840.00	\$746.00	\$991.00	\$1,334.00
Customer Service	866-355-5999 8-8 CT (Mon-Fri)			



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